CLAIMANT STATEMENT
CLAIM FORM

CONTINENTAL AMERICAN LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER L. KEARNEY Date of Birth 11/9/52
Policy No. H 493025 + H 538046

1. I was residually disabled from 2/8 19 93 to present 19 ___.

2. During this period of residual disability I was unable to perform the following important daily business duties of my occupation 70-80% ___ I was able to perform all of the usual daily business duties of my occupation, but only for ____% of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on March 19 94.

4. I was under the care and attendance of a physician from April 19 93 to present 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 5 AND 6, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

5. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the ✓ prior calendar year ___ prior twelve consecutive months earnings to determine this average.

6. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$1500.00	Dec.	'93						

Any information necessary to verify the answers I have given above will be furnished upon receipt.

Date 1-5- 19 93 Signed Christopher L. Kearney (Claimant)

12168 Village Woods Dr. Cincinnati OH
(Street Address) (City or Town) (State)

45241 (Zip Code)

PLEASE ATTACH THIS FORM DIRECTLY TO THE SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER L. KEARNEY Policy No. H538069 H490029

1. I was residually disabled from Feb 8 19 93 to Present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 70-80 % of the time usually required to perform these duties. — guess

3. I expect to return to the full performance of my occupation on Not (Uncertain) 19 93.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166.00 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$ 0.00	Feb.	'93	$ 00.00	Mar.	'93	$ 4000.00	Apr.	'93
$ 3000	May	93	$ 6000.00	June	'93			

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 7-10 19 93 Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

H. 538069

Name in Full CHRISTOPHER L. KEARNEY Policy No. H. 493029

1. I was residually disabled from Feb 8 19 93 to Present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 70-80 % of the time usually required to perform these duties. ~guess

3. I expect to return to the full performance of my occupation on Dec, Nov (tentative) 19 93.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166.00 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$2000.00	July	'93						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 8-9 19 93 Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

FAXED 9-2-93

Name in Full CHRISTOPHER L. KEARNEY Policy No. H.493029/H.538069

1. I was residually disabled from Feb 8 19 93 to Present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation_____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 80 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on Nov. (tentative) 19 93.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166.00 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B)___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$2000.00	Aug	'93						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 9-2 19 93 Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

FAXED 10-7-93

Name in Full CHRISTOPHER L. KEARNEY Date of Birth 11/9/52
Policy No. H 693025 + H 538169

1. I was residually disabled from Feb 8 1993 to present 19___.

2. During this period of residual disability I was unable to perform the following important daily business duties of my occupation_____
_____
_____ I was able to perform all of the usual daily business duties of my occupation, but only for 70-80 % of the time usually required to perform these duties.

3. I expect to return to the full performace of my occupation on Jan or Feb 1994.

4. I was under the care and attendance of a physician from April 1993 to present 19___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 5 AND 6, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

5. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the ✓ prior calendar year ___ prior twelve consecutive months earnings to determine this average.

6. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
#5,500.00	Sept	'93						

Any information necessary to verify the answers I have given above will be furnished upon receipt.

Date Oct 7 1993 Signed Christopher L. Kearney
(Claimant)

12168 Village Woods Dr. Cincinnati OH
(Street Address) (City or Town) (State)

45241 (Zip Code)

PLEASE ATTACH THIS FORM DIRECTLY TO THE SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER L. KEARNEY Date of Birth 11/9/52
Policy No. H 493025 + H 53806

1. I was residually disabled from FEB 8 19 93 to present 19 ___.

2. During this period of residual disability I was unable to perform the following important daily business duties of my occupation _____
_____ I was able to perform all of the usual daily business duties of my occupation, but only for 80 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on Feb 19 94.

4. I was under the care and attendance of a physician from APRIL 19 93 to present 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 5 AND 6, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

5. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the ✓ prior calendar year ___ prior twelve consecutive months earnings to determine this average.

6. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$1500.00	Oct	93						

Any information necessary to verify the answers I have given above will be furnished upon receipt.

Date 11-10 19 93 Signed Christopher L. Kearney
(Claimant)

12168 Village Woods Dr. Cincinnati OH
(Street Address) (City or Town) (State)

45241 (Zip Code)

PLEASE ATTACH THIS FORM DIRECTLY TO THE SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

FAXED 12-1-93

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER L. KEARNEY Date of Birth 11/9/52
Policy No. H 493025 + H 53806

1. I was residually disabled from 2/8 19 93 to Present 19 ___.

2. During this period of residual disability I was unable to perform the following important daily business duties of my occupation _____
_____
_____ I was able to perform all of the usual daily business duties of my occupation, but only for 70-80 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on Feb 19 94.

4. I was under the care and attendance of a physician from April 19 93 to Present 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 5 AND 6, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

5. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the ✓ prior calendar year ___ prior twelve consecutive months earnings to determine this average.

6. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
9/1500.00	Nov.	'93						

Any information necessary to verify the answers I have given above will be furnished upon receipt.

Date 12-1 19 93 Signed Christopher L. Kearney
(Claimant)

12168 Village Woods Dr. Cincinnati OH
(Street Address) (City or Town) (State)

45241 (Zip Code)

PLEASE ATTACH THIS FORM DIRECTLY TO THE SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER L. KEARNEY Date of Birth 11/9/52
Policy No. H 493025 + H 538 06

1. I was residually disabled from 2/8 19 93 to present 19 ___.

2. During this period of residual disability I was unable to perform the following important daily business duties of my occupation ~~[illegible]~~ _____ I was able to perform all of the usual daily business duties of my occupation, but only for 70-80 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on March 19 94.

4. I was under the care and attendance of a physician from April 19 93 to present 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 5 AND 6, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

5. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the ✓ prior calendar year ___ prior twelve consecutive months earnings to determine this average.

6. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$1500.00	Dec.	'93						

Any information necessary to verify the answers I have given above will be furnished upon receipt.

Date 1-5-94 Signed Christopher L. Kearney
(Claimant)

12168 Village Woods Dr. Cincinnati OH
(Street Address) (City or Town) (State)

45241 (Zip Code)

PLEASE ATTACH THIS FORM DIRECTLY TO THE SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER L. KEARNEY Date of Birth 11/9/52
Policy No. H 493025 + H 53806

1. I was residually disabled from 2/8 19 93 to present 19 ___.

2. During this period of residual disability I was unable to perform the following important daily business duties of my occupation _____
_____ I was able to perform all of the usual daily business duties of my occupation, but only for 75 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on March 30 19 94

4. I was under the care and attendance of a physician from April 19 93 to present 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 5 AND 6, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

5. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the ✓ prior calendar year ___ prior twelve consecutive months earnings to determine this average.

6. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$ 1500.00	Jan	'94						

Any information necessary to verify the answers I have given above will be furnished upon receipt.

Date 2-8 19 94 Signed Christopher L. Kearney (Claimant)

12168 Village Woods Dr. (Street Address) Cincinnati (City or Town) OH (State)

45241 (Zip Code)

PLEASE ATTACH THIS FORM DIRECTLY TO THE SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER L KEARNEY Date of Birth 11/9/52
Policy No. H 493025 + H 53806

1. I was residually disabled from 2/8 19 93 to present 19___.

2. During this period of residual disability I was unable to perform the following important daily business duties of my occupation_____
_____
_____ I was able to perform all of the usual daily business duties of my occupation, but only for 75 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on _____ 19___. Although sore, my back should not hinder performance and long

4. I was under the care and attendance of a physician from April '93 19 93 to present 19___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 5 AND 6, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

5. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the V prior calendar year ___ prior twelve consecutive months earnings to determine this average.

6. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$1800.00	Feb	'94	$1800.00	March	'94			

Any information necessary to verify the answers I have given above will be furnished upon receipt.

Date 3-30 19 94 Signed Christopher L Kearney
(Claimant)

10979 REED HARTMAN HWY CINCINNATI OHIO
(Street Address) (City or Town) (State)

45242 (Zip Code)

PLEASE ATTACH THIS FORM DIRECTLY TO THE SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER L. KEARNEY Policy No. H538069 H493029

1. I was residually disabled from 2/8 19 93 to present 19 __.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation Not able to work as effectively. Not able to ~~be~~ focus, travel as much or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 50 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on don't know 19 __.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166.00 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$2000.00	4	94	$2000.00	5	94	$2,000	6	94

$2000.00 7/94; $2000 8/94; $2000 9/94; $2000.00/10/94

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 10/31 19 94 Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER L. KEARNEY Policy No. H538069 H498029

1. I was residually disabled from 2/8 1993 to present 19___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation_____

_____

_____or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 50 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B)___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$2000.00	Nov.	'94	$2000.00	Dec	'94			

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 2/15 1995 Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER L. KEARNEY Policy No. H538069 H498029

1. I was residually disabled from 2/8 19 95 to present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 50 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$2000.00	Feb.	1995						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 3-6 19 95 Signed Christopher L Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER L. KEARNEY Policy No. H.493029 H.538069

1. I was residually disabled from 2/8 1993 to present 19___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 60 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B)___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$ 2000.00	Mar	1995	$ 2000.00	Apr	1995			

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 5-1- 1995 Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER L. KEARNEY Policy No. H5380695 H490029

1. I was residually disabled from 2/8 19 93 to present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 60 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$1800.00	May	1995						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 6-1 1995 Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

H.538069

Name in Full CHRISTOPHER L. KEARNEY Policy No. H.493029

1. I was residually disabled from 2/8 19 93 to present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 60 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
2000 00	June	1995						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 7-13 19 95 Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER L. KEARNEY Policy No. H.493029 H.538069

1. I was residually disabled from 2/8 1993 to present 19___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation_____

_____

_____or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 60 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166.00 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B)___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$2000/	July	1995						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 8-4 1995 Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER L. KEARNEY Policy No. H-538069 H-493029

1. I was residually disabled from 2/8 1993 to present 19___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation_____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 60-70 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B)___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$2000.00	Aug	95						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 9-11 1995 Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

H 538069

Name in Full CHRISTOPHER L. KEARNEY Policy No. H493029

1. I was residually disabled from 2/8 1993 to present 19___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B)___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$2000.00	9	95						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 10-2 1995 Signed Christopher Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER L. KEARNEY Policy No. H-493029 H-538064

1. I was residually disabled from 2/8 19 93 to present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on ASAP 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$2000.00	10	95						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 10-31 19 95 Signed Christopher Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

JEFFERSON-PILOT LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER KEARNEY Policy No. H-538069 H-493029

1. I was residually disabled from 2/8 19 93 to present 19___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____ _____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)
I used the (A) ✓ prior calendar year (B)___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$ 2000	11	95						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 12-1 1995 Signed Christopher Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.